

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>390001</b>	(X2) MULTIPLE CONSTRUCTION:  A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED:  <b>07/20/2023</b>
NAME OF PROVIDER OR SUPPLIER: <b>GEISINGER-COMMUNITY MEDICAL CENTER</b>  STATE LICENSE NUMBER: <b>037101</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>1800 MULBERRY STREET SCRANTON, PA 18510</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE	
P 0000	<p>INITIAL COMMENT</p> <p>This report is for the new service, inpatient Telemedicine Service for the Cardiology Service Line, beginning on July 12, 2023. The Geisinger - Community Medical Center attested they were in full compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Hospitals, 28 PA Code, Part IV, Subparts A and B, November 1987, as amended June 1998.</p>	P 0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:



# Certified End Page

**GEISINGER-COMMUNITY MEDICAL CENTER**

**STATE LICENSE NUMBER: 037101**

**SURVEY EXIT DATE: 07/20/2023**

**I Certify This Document to be a True and Correct Statement of Deficiencies and  
Approved Facility Plan of Correction for the Above-Identified Facility Survey**

A handwritten signature in black ink that reads "Jeane Parisi".

*Jeane Parisi*  
*Deputy Secretary for Quality Assurance*

A handwritten signature in black ink that reads "Debra L. Bogen MD".

*Debra L. Bogen, MD, FAAP*  
*Acting Secretary of Health*



THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY